WAIVER COMMENTS AND RESPONSES	
COMMENTS	**RESPONSE**
• Personal Care Limitation: Individuals who live in licensed residential facilities, AFLs, licensed foster care homes or unlicensed AFLs may not receive this service. Some individuals will need more PC than is provided through residential placements; failure to provide could result in increased institutional placement.	• Personal Care as a stand-alone service is not permitted in these facilities because the Residential Support definition is designed to meet both the active treatment needs as well as personal care needs of individuals in residential settings. The level of habilitation and active treatment is based on the needs of the individual and reflected in the Plan of Care and is to be provided based on the natural flow of the person's day. The language in the definition has been clarified to clearly reflect the personal care components of the definition. Issue to be brought to the attention of rate setting and manual writing teams.
• Personal Care Limitation: The service does not include medical transportation and may not be provided during medical transportation and medical appointments.	• Medical transportation is included in the State Medicaid Plan and therefore cannot be covered under the Waiver.
• Supported Employment language encourages businesses to pay individuals with disabilities less than the minimum wage.	• The definition in the Waiver is the suggested definition in the Waiver template provided by CMS. This definition remains the same as the current definition. Nothing in the definition prohibits an individual from being paid at or above the minimum wage. This issue will be addressed through the Manual Writing Team.
• Language in regard to legal guardians providing services and **NOTE** in provider qualifications is confusing.	• The Waiver language has been revised to address concerns regarding the provision of services by guardians, as well as immediate family members. Changes include the following: For the purpose of this waiver, immediate family means parent or step-parent of a minor child, or spouse. Legal guardians of the person may provide waiver services to individuals since they are not financially responsible for the individual.
• Will there be two levels of Personal Care and Respite?	• There will be two levels of both Personal Care and Respite. The enhanced levels are intended to address the needs of individuals with significant behavioral challenges and/or medical needs, living in their own home or with their natural family, as identified through the NC-SNAP and indicated in the Plan of Care. As indicated in the provider qualifications, there will be increased training requirements for staff providing enhanced levels of care.

▪ Residential Support definition: Clarify the limitation that payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Adult Medicaid recipients are not prohibited from receiving services from a member of their immediate family.	• Language in the definition has been revised to clarify this concern. For the purpose of the waiver, immediate family means parent or step-parent of a minor child, or spouse.
• Utilization Review Tool: This is an integral component of the waiver and we would like the opportunity to review and provide feedback.	• As noted in the waiver, Lead Agencies must adhere to a standardized, statewide UR criteria and process. This Tool is currently being completed by the Waiver Team. There will be an opportunity for stakeholder feedback.
• What does the statement "This service provides assistance in the workplace with activities not already required or funded by other sources or services, including travel assistance" mean?	• It is agreed that this language is confusing and therefore it was removed from the Personal Care definition. Location of services will be more fully addressed within the Manual.
• Respite: Can group home residents no longer receive respite services when they are staying at home with their parents or family?	• Correct. Respite is intended for the relief of the primary caregiver; for individuals living in residential settings the primary caregiver is the residential staff. Relief for staff in group homes and other residential settings is reflected through rates.
• Respite: May be clearer to say that "other family members, such as the siblings of the individual may not receive care or supervision from the provider while respite care is being provided to the individual".	• Language in the definition has been changed to reflect this suggestion.
• What is FFP?	• Federal Financial Participation
• Residential Supports: Will this service require a 1:1 staffing ratio. Is it an hourly periodic service or will it have a daily rate?	• This service is designed to simplify the service array and to provide services that reflect the natural flow of a waiver participant's day. Since it is a blended service that includes both habilitation and personal care the level of habilitation as well as Personal Care needed should be reflected in the Plan of Care. This service will have a daily rate and level of staffing will be reflected by the individual needs of the participant. 1:1 will not be required unless the individual's Plan of Care reflects that it is needed.
• Is Appendix G available for review?	• Appendix G is a highly technical component of the waiver application intended to meet the cost neutrality requirements of the waiver. Changes continue to be made to service definitions based on stakeholder feedback. The final Appendix G will be posted on the DMH/DD/SAS website.

• The 8 bed limitation on Residential Supports definition is likely to have a negative impact on the Olmstead initiative and our ability to serve some of the most challenging consumers in the community.	• Individuals who live in licensed group homes or adult care homes with more than 8 beds and who are participating in the CAP-MR/DD waiver at the time of the implementation of this waiver may receive Residential Supports. The move to aggregate funding versus slot funding will provide for individuals to receive waiver funding needed to meet their needs based on person centered planning and statewide utilization review criteria, so individuals will be supported to move from institutional care into the community. The federal Centers for Medicare and Medicaid Services (CMS) has increasing expectations that states reduce their reliance on congregate living settings. The draft CMS waiver template currently being proposed requires that states indicate the maximum number of individuals who may be served in facilities. Independence Plus waiver templates limit the number of beds in residential settings under the waiver to four individuals. The intent of our proposed waiver definitions and move to aggregate funding is to promote and support the Olmstead decision. The proposed waiver has built both flexibility in service definitions as well as aggregate funding in order to provide individuals with the service array and funding needed to meet their individual needs. Current CMS policy promotes the move away from reliance on congregate settings to more homelike environments. With the proposed definitions and corresponding statewide, standardized utilization review process under development, individuals with the highest needs will be enabled to be served in their communities with the supports needed.
• Day Supports: Is transportation no longer included in the definition?	• The language has been revised to clearly reflect transportation.
• Day Supports: Will there be a group component to this service?	• Yes, since the service is provided by congregate licensed day programs a group component will be available as with previous Day Habilitation definition. On site attendance at the licensed facility is not required to receive services that originate from the facility.
• Supported Employment: Why must this service be authorized every six months?	• The purpose of reauthorization is to monitor achievement of outcomes and to ensure continued need for the service.
• Home and Community Supports: Is this a blended service?	• This service is blended in that it provides for both habilitation, training, and instruction coupled with elements of support, supervision, and engaging the consumer. Home and Community Supports is intended to provide instruction and assistance to maintain skills and allow greater independence in the community. It does provide for support and supervision to reflect the natural flow of the day.

• Is it possible for Residential Supports, Day Supports, Supported Employment, and Home and Community Supports to be provided on any given day?	• The service or services that a person receives should be based on the individual person centered plan. For an individual who lives in a residential setting, the person will receive Residential Supports and the Plan of Care will indicate the service array needed in the community. The range of day programming could include a job without paid supports at all, to part time supported employment with day supports OR the community component of Home and Community Supports. It is extremely unlikely that a person would have a complex day program array that would involve all services.
• For services that have either a fiscal or maximum number of hours available per waiver year, is it possible to have the limitations be based on the individual's plan year vs. waiver year?	• The annual limitations will be set in the billing/edit system per the waiver year. The limitations for home and vehicle adaptations are over the three years of the waiver and will need to be tracked locally for each participant.
• Specialized Equipment and Supplies: Will the statement that "Items under this service shall be directly attributable to the person's ability to avoid being institutionalized" be a problem with approval of some items on the list?	• No, this is in the current waiver and has not presented a problem. The intent of all waiver services is to prevent institutionalization.
• Has category four been removed from the Specialized Equipment and Supplies definition?	• Yes, although adaptive tricycles have been added to category two.
• Augmentative Communication: Please clarify the use of the Assistive Technology Professional and the assistance with selection of devices by these professionals.	• This was included in the definition at the request of stakeholders. The intent is to provide for ensuring that the equipment that best meets the adaptive needs of the individual are acquired. The assistance may not duplicate evaluations and services provided by licensed speech, occupational, and/or physical therapists. A description of the Assistive Tech professional has been added to the provider qualifications and further clarification will be provided through the Manual Team.
• Augmentative Communication: Can Augmentative communication devices that are purchased for use at home be used at school?	• Equipment belongs to the waiver participant and the participant may choose to take the augmentative communication device to school. Devices that are required for use at school (and not needed for use at home) are not available under this definition and should be purchased by the school system.
• Crisis Services: Great changes to this service from the current Crisis Stabilization service. I believe the changes will make this a much more viable service and easier to utilize.	▪ Thank you!

• Do relatives providing services have to meet the same qualifications as other providers?	• Yes.
• Can computers be purchased under the Augmentative communication definition as they are now?	• Yes, assuming that the computer is medically necessary as defined in the definition.
• Under the new waiver, who will determine Level of Care?	• The waiver proposes that the level of care determination be made by the LME rather than EDS. The waiver also proposes that the MR-2 be signed by either a MD or licensed psychologist. DMA and DMH/DD/SAS will continue to do quality reviews of this process. This is similar to the look behinds currently done as part of the Local Approval Monitoring of Continued Ned Reviews/Annual Plans. The details of the process, if approved by DMA and CMS, will be described in the Manual.
• There needs to be further clarification in regard to appeal rights.	• Questions in regard to the Appeals process will be clarified in the Manual and/or addressed to the Division Affairs Team. The letter to individuals regarding the appeals process is currently under review.
• Several changes in the Plan of Care were felt to be hard to understand.	• Clarifications to the Plan of Care will be addressed through the Manual.
• Changes in the Cost Summary will require a new template. Can the Division develop one?	• DMH/DD/SAS will develop a new template but cannot guarantee that it will work across all software systems due to the varying systems used by LMEs.
• What assurances do current waiver enrollees have that they will continue to receive personal care services sufficient in amount, duration and scope necessary for their health, safety and welfare?	• Services to all waiver participants are based on individual needs and preferences and must be clearly identified in the Plan of Care. Health and safety will be assured for all Waiver participants. In addition, service definitions have been reviewed and revised based on stakeholder feedback to assure that individual needs can be met.
• Will waiver participants continue to have freedom of choice concerning their case managers under Targeted Case Management?	• Yes.
• Can transportation be provided when transportation is unavailable during times vans or lifts are being repaired?	• This is not covered under the proposed waiver; however, Medicaid medical transportation through DSS is available for medical appointments.

• Targeted Case Management Comment: The inclusion of disallowing a case management agency to provide other services should ensure there is not a conflict of interest and the consumer will benefit.	▪ This issue will be addressed in the Manual.
• Supported Employment: Recommend that there be more of an effort to individualize Supported Employment.	• All services are intended to meet the individual needs and preferences of the individual based on the person centered plan (Plan of Care).
• Plan of Care: Recommend addition of a behavior plan as a component of the Plan of Care.	• This is currently a part of the planning process and is expected to continue with the new waiver. Both DMA and DMH/DD/SAS monitor this need during monitoring of the Plan of Care approval process.
• Home Modifications: Should cover turnaround space with ramps. Should also include adding fencing for the safety of individuals to ensure protection from outside predators, weather protection of multiple home entrances, and modification of rooms for therapeutic purposes.	• Turnaround space is a component of installation of ramps. Fences continue to be available under Home Modifications to ensure the health, safety and welfare of ambulatory waiver participants who live in private homes and do not receive paid supervision for ten hours per day or more.
• Specialized Equipment and Supplies: A number of suggestions were made regarding specific additions to items for this definition.	• All suggestions were carefully reviewed and due to concerns about the requested items they will not be added to the waiver at this time. Items that are mentioned for adults only are due to the same items for children being covered under the State Medicaid Plan and therefore cannot be covered by the Waiver.
• Individual/Caregiver Training: Can the definition include payment for lodging at conferences?	• No, federal regulations will not allow covering room and board for waiver participants or their families at conferences. We have also excluded transportation for families to conferences after learning that CMS will not allow this as part of the service definition.
• Augmentative Communication: Should also cover when fine motor skills impact ability to communicate effectively.	• The intent of the definition is to provide devices when normal speech is impaired.
• Augmentative communication: Should include repairs?	• Language has been added to clarify inclusion of repairs.
• Recommend an increase in the limit on Specialized Consultative Services and Individual/Caregiver Training.	• The limit was established based on actual usage; the limit will not be raised at this time.
• Vehicle Adaptations: Recommend automatic steps are included.	• This is not being included since the definition contains other modifications that would allow a person with physical disabilities to access a van.

• Level of Care: It is recommended that the re-evaluation of LOC only occur every 3 years.	• Federal regulations require an annual re-assessment of LOC.
• Training on the new waiver should be provided regionally.	• The Waiver and Manual Team are reviewing options for training and will take this under consideration.
• Should the service names remain the same as they are in the current waiver?	• Some of the service names were changed because of the national coding initiative. Others were renamed because of other changes taking place in the State around service provision and consistency across the State.
• What does the phrase "waiver services to be delivered out of the state are subject to the same requirements as services delivered out of state under the State Plan" mean?	• The State Medicaid Plan allows for service delivery out of state for specific reasons that will be listed in the new Manual.
• Personal Care: Both registered nurse and Qualified Developmental Disabilities professional supervision is checked. Is this specific to the type of license a vendor may have? Does frequency of supervision refer to staff or consumers?	• Licensing of the provider agency will determine type of supervision. Frequency of supervision refers to staff.
• Limiting Personal Care in unlicensed homes can hurt the consumer who may primarily need this service.	• Individuals currently receiving Personal Care services in unlicensed Alternative Family Living arrangements will receive Residential Supports under the new waiver. This service is inclusive of personal care. The level of habilitation and training provided is based on the needs of the individual.
• Please clarify the definition of AFL (Alternative Family Living arrangement).	• Reference 10 A NCAC 27G.5601 (c) (6): F designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnosis is mental illness but may also have other disabilities, or 3 adult clients or three minor clients whose primary diagnosis is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This is a Supervised Living license.
• Clarify Home and Community Support reference to sustaining skills gained through habilitation and training as an acceptable goal.	• This basically refers to the ability of the provider to provide needed support and supervision to an individual in order to maintain skills that have previously been gained.

• Home and Community Supports: Elaborate on "consumers in group homes can receive only community component of Home and Community Supports".	• Individuals in licensed residential settings or unlicensed AFLs may only use the community component of Home and Community Support. The community component of Home and Community Supports does not replace the Residential Support provider's responsibility to provide support to individuals in their homes and the community, but is intended to support those who choose to engage in community activities that are not provided through a licensed day program. In other words, if an individual in a residential setting receiving Residential Supports chooses not to participate in day programming through a licensed day facility, the community component of Home and Community Support can support day activities not typically provided by the residential provider.
• Home Modifications: Does limitation on fencing approved for individuals receiving 10 hours of paid supervision include time in school?	• No.
• Home Modifications: Clarify issues regarding tracking of $15,000 limit over a 3-year period.	• This will be clarified through the Manual.
• Individual/Caregiver Training: Who does training on use of specialized equipment apply to in this definition?	• The individual or the family members only.
• There appears to be some overlap in Augmentative Communication and Individual/Caregiver Training definitions.	• There is no overlap. The Augmentative Communication definition includes technical assistance provided to individuals in the selection of augmentative communication devices by qualified augmentative communication technology professionals. This assistance may not duplicate evaluation and services provided by licensed speech, occupational, and/or physical therapists. The individual/caregiver training definition or specialized consultative services definitions could provide training of consumer/families on the use of the selected equipment after it has been purchased and provided to the person.
• What is the difference between Individual/Caregiver Training and Specialized Consultative Services?	• Specialized Consultative Services are highly specialized and provided by licensed professionals to provide expertise, training, and technical assistance in a specialty area to assist family members, caregivers, and other direct service employees in supporting individuals with developmental disabilities to increase the effectiveness of the specialized therapy. Individual/Caregiver Training is not required to be provided by licensed professional and may only be provided to the participant and his/her unpaid caregivers. The service may not be provided to paid staff.

• Do we need criminal background checks for Individual/Caregiver Training?	• Division rules must be followed for all services.
• Why is the Division including a Plan of Care with the waiver application rather than following the Service Records Manual?	• CMS requires that a structured Plan of Care accompany the waiver application.
• Will regular Medicaid costs be tracked on the Cost Summary?	• No. This will no longer be required; however, the LME needs to remain aware of regular Medicaid services that are being provided to the individual. Further clarification on completing the Cost Summary will be addressed through training and the Manual.
• Are AFL providers eligible for respite care?	• Yes.
• Are Day Supports intended to serve only children?	• Day Supports are intended to serve both children and adults whose service originates in a licensed day program. It is not a requirement that the service be provided on site.
• Is Home and Community Supports a daily or periodic service?	• Home and Community Supports is a periodic service that will include both individual and group rates.
• To whom does the acronym D. O. refer?	• Doctor of Osteopathy. A doctor of osteopathic medicine is a physician licensed to perform surgery and prescribe medication. Like an M.D., an osteopath completes 4 years of medical school and can choose to practice in any specialty of medicine.
• Need to explain why the LME is listed as a provider for all services under Provider Qualifications yet services cannot be provided by the LME.	• Due to the varying levels of divestiture at this time; capacity for the LMEs to provide services needs to remain in the waiver.
• Why is the LME listed as the only qualified provider for the Transportation service?	• Because it is the LME that bills Medicaid for the service. For instance, the LME purchases bus tickets for the consumer and then bills DMA for reimbursement.
• How will monitoring done by the agency Qualified Developmental Disabilities professional, case managers, LMEs, DMH/DD/SAS and DMA avoid costs of duplication?	• Each of these individuals or entities has a role in the overall monitoring processes to ensure health and safety of participants. These roles have always been in place. Specific processes will be more fully discussed both in the Manual and training as well as the Quality Management document attached to the waiver.
• Case Management: What are closely allied entities or related partners?	• Other entities with which the provider agency has either a formal, legal connection or informal agreements or partnerships. The intent is to ensure that waiver participants are free from conflicts of interest.

• Case Management: Case Managers are noted to oversee the process of assessment and reassessment; this appears to be in conflict with evaluation and re-evaluation.	• Case managers will continue to be responsible for both overseeing the process of assessment both for the initial eligibility as well as continued need review annually. This is not a change.
• What is Targeted Case Management? How is it different from current Case Management?	• The term Targeted references the specific population to which the service of case management is directed. In the case of the waiver, the targeted group is individuals with developmental disabilities. The functions of Targeted Case Management remain the same; however, the service is no longer funded through the waiver but through the State Medicaid Plan.
• Need an explanation of "assistance with monitoring of health status and physical condition". Need to be careful that the interpretation is at a level consistent with training and knowledge of personal care staff. Also have concerns with assistance with transferring, ambulation and use of special mobility devices?	• Provider qualifications require that client specific competencies be met as identified by the individual's person centered planning team and documented in the Plan of Care. Under the current waiver, ambulatory assistance and training in tasks and medical monitoring such as monitoring of vital signs, recognizing and reporting symptoms of illness and changes in health condition, crosswalk to the new definition.
• Day Supports: Why only in licensed facilities?	• It is the intent of this waiver to provide services that are flexible and provide for ease in service provision as requested by stakeholders. Individuals receiving day programming through licensed facilities will bill Day Supports while those receiving day programming through unlicensed providers will bill through Home and Community Supports. On site attendance at the licensed facility is not required to receive services that originate from the facility.
• Case Management: Please clarify the role of case management vs. Qualified Developmental Disabilities professional within the waiver application.	• Case managers must be Qualified Developmental Disability Professionals for the purpose of the waiver. Language has been added to the waiver in the provider qualifications to clarify this.
• Case Management: In Appendix E it is noted that the case manager is responsible for the Plan of Care. This seems to differ from the service definition of Targeted Case Management.	• Case Managers are currently and will continue to be responsible for the Plan of Care.
• Plan of Care format: ICF-MR should not be included under Residency since waiver services may not be provided in and ICF-MR facility.	• This has been removed from the Plan of Care format.
• Plan of Care format: Signature page should reflect the choice to	• Language has been changed in the Plan of Care to reflect

change not only service providers but case managers.	this.
• When caregivers are in our home and the therapist (PT, OT, Speech) is here at the same time, how can we get them both paid without double billing?	• Medicaid regulations do not allow two services to be billed simultaneously.
• Part of the accountability of providers should be that the workers are tested on what they know about the goals every few months by the Qualified Developmental Disabilities professional and Case Manager.	• Qualified Developmental Disabilities professionals employed by provider agencies are responsible for ensuring that staff understand the goals that they are expected to implement and are able to carry them out according to the Plan of Care. Case Managers are responsible for ensuring that services are provided according the Plan of Care and must make a monthly face-to-face visits.
• Are Pre-Vocational services included within this waiver?	• No. The overall intent of this waiver is to provide flexibility and simplicity in service delivery through fewer services. Day Supports is the service intended to address the needs of individuals in licensed day settings such as ADVP which may provide prevocational training.
• Individual/Caregiver Training: Does "family" include roommates/housemates?	• If the roommate/housemate of an individual is providing some level of unpaid care to the individual it is possible that they could be included for the purpose of this definition.
• Who may question Level of Care as noted in Appendix D?	• The proposed waiver provides for initial Level of Care reviews to occur at the LME level as part of the Utilization Review and Authorization process. Utilization Review and Authorization of services is provided by a Qualified Developmental Disabilities professional trained and competent to approve Plans of Care. Reauthorization must occur annually through UR at the LME. If a second level of review is needed at reauthorization, a physician or licensed psychologist will complete a new MR2.
• Eight (8) bed limitation on use of Residential Supports: Behavioral or medical issues necessitate a setting where several staff members are available to assist if needed or where individuals can receive assistance with health related concerns.	• The proposed waiver has built both flexibility in service definitions as well as aggregate funding in order to provide individuals with the service array and funding needed to meet their individual needs. Current CMS policy promotes the move away from reliance on congregate settings to more homelike environments. With the proposed definitions and corresponding statewide, standardized utilization review process under development, individuals with the highest needs will be enabled to be served in their communities with the supports needed.

• When it is time to put the appropriate service in the plan, who has the final say as to what is the appropriate service?	• The Person Centered Plan should describe what the person needs and should be written from the person's perspective rather than in terms of the availability of services in the Waiver. The Plan should also describe natural and community supports available to the person. If paid supports are needed in addition to the natural and/or community supports, the service is determined based on the person's needs. If the person centered plan accurately describes what the person needs, then the service that the person needs should be clear. The Local Management Entity has the ultimate approval authority for the Plan of Care.